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INSTRUCTIONS FOR COMPLETING THE ADJUSTED COMMUNITY RATE PROPOSAL FOR CONTRACT YEAR 2001

Contents

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Introduction

Each Medicare+Choice (M+C) organization must compute a separate adjusted community rate (ACR) for each M+C coordinated care, private fee-for-service, or religious fraternal benefit plan it offers to Medicare beneficiaries. The ACR computations must be made and submitted to the Health Care Financing Administration (HCFA) on its ACR forms. An M+C organization that offers an M+C plan with a medical savings account (MSA) must submit certain information (described later) on ACR forms, but does not need to submit complete ACR calculations.

In addition to the ACR calculations, M+C organizations must submit to HCFA some additional supporting material that will be described later. All data submitted as part of the ACR process are subject to audit by HCFA or any person or organization that HCFA designates.

ACR forms for contract year (CY) 2001 have been revised to address comments and suggestions HCFA has received from M+C organizations and others about ways to improve ACR proposals in the light of experience with the CY 2000 Adjusted Community Rate Proposal (ACRP) process. For example, revisions to the forms, methodology, and instructions simplify the ACR methodology and submission, reduce the amount of reporting and backup needed, and provide more flexibility to users. The revised forms are consistent with the requirements of the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), and related HCFA rules and regulations.

To compute its ACR for CY 2001, an M+C organization calculates an initial rate for the contract year and reports collections (on an accrual basis) from non-Medicare enrollees in the base period (i.e., the year beginning 2 years before the contract year). The initial rate represents the average "commercial (i.e., non-Medicare) premium" that the M+C organization would charge its general non-Medicare-eligible population for the basic benefits and any supplemental benefit (both mandatory and optional) covered under the M+C plan. The initial rate (and selected components) are compared to the base period collections from M+C organization enrollees (and selected components) to produce 2-year non-Medicare trend factors. At that point, the trend factors are applied to base period Medicare costs to produce Medicare costs for the contract year. M+C organizations that did not have or don't expect to have non-Medicare enrollees should follow the ACR methodology discussed later.

The CY 2001 ACR methodology just described eliminates the relative cost ratios used to calculate ACRs for CY 2000. However, the new methodology, while simplified, produces results that are similar to the CY 2000 ACR calculation.

An M+C organization may contract with HCFA to offer several M+C plans including coordinated care plans (e.g., health maintenance organizations [HMOs], preferred provider organization [PPO] plans); religious fraternal benefit plans; MSAs; and private fee-for-service (PFFS) plans. Each type of M+C plan would have its own service area. M+C benefit packages offered under the various M+C plans could have different additional benefits, mandatory supplemental benefits, optional supplemental benefits, and pricing structures.

An M+C organization must offer an M+C plan containing a specific set of benefits at the same price to every Medicare beneficiary throughout the plan's service area. The M+C plan offered to Medicare beneficiaries must contain all items and benefits covered under original Medicare (except hospice care) and any required additional benefits. The M+C organization can offer (with agreement by HCFA) mandatory supplemental benefits as part of the specific set of benefits. Finally, the M+C organization can augment its plan with supplemental benefits that Medicare beneficiaries can purchase at their option. M+C organizations may develop other M+C plans with associated optional supplemental benefits to be offered to Medicare beneficiaries. Each M+C plan and its associated optional supplemental benefits must be offered throughout the service area of the M+C plan. Each such plan may include a different pricing structure, different additional benefits, different mandatory supplemental benefits, and/or different optional supplemental benefits.

M+C organizations must use HCFA's ACR forms to develop a pricing structure for a particular M+C plan. The information must be submitted in the electronic format using Excel 97. (NOTE—If you use a version newer than Excel 97 to complete HCFA's electronic ACR worksheets, please save the file as an Excel 97 file before you submit the electronic worksheets to HCFA.) A paper copy of your complete ACR containing a signed certification on Worksheet A must be submitted too. The Office of Management and Budget (OMB) has approved the ACR format and has determined that the worksheets are necessary for the government's efficient operation and do not impose an unnecessary paperwork burden on M+C organizations.

An M+C organization must submit these forms by July 1 of each year for each M+C plan offered in the next year. New applicants intending to contract with HCFA before 2002 should contact the HCFA plan manager assigned to their organization to learn the due date of the forms. For 2002 and subsequent years, new applicants will be subject to the same deadlines as existing contractors.

Each M+C organization must submit a separate ACR proposal for each M+C plan that the organization intends to market in a given service area. Because M+C plans covering Part B-only enrollees are separate from M+C plans serving enrollees eligible for both Part A and Part B of Medicare, organizations must submit separate ACR forms for any M+C plan(s) covering Part B-only Medicare enrollees. An M+C organization will have Part B-only enrollees if it was a Section 1876 contractor on December 31, 1998, and if it had Medicare enrollees who had Medicare coverage only under Part B and who did not terminate their membership before January 1, 1999.

ACR approval will take place during the spring or summer months so that information can be sent to and used by the Medicare beneficiary during the open enrollment period (November of each year).

If you have any questions about the content of these worksheets, please e-mail them to HCFA via its web site at www.hcfa.gov.

What's New for the CY 2001 ACR

As has been stated, the ACR forms for CY 2001 have been revised to simplify the methodology and submission, to reduce the amount of reporting needed, and to provide users more flexibility. This section contains a list of significant changes to the forms.

Simplified ACR Methodology and Submission

- A new ACR methodology eliminates relative cost ratios without changing the results.
- The new ACR forms have more internal self-validating features, such as color highlighting to flag missing or unneeded entries as well as error messages warning of mistakes (e.g., numbers with wrong signs, text entries in number cells, non-valid state-county codes).
- Separate software is available to validate ACRs before upload.
- Certification requirements have been eased for certain changes to initial ACR submissions.
- Drop-down menus have been introduced on electronic worksheets to simplify data entries.

Reduced Reporting Requirements

- Detailed data on base period non-Medicare costs by health care component are no longer needed. Only summary non-Medicare data (direct medical, administration, and additional revenue) are required.
- Contract year cost-sharing data for non-Medicare enrollees are no longer required.
- A standardized worksheet with links to HCFA data is available for calculating the average payment rate.
- Requirements for certain non-financial base period data have been eliminated.

Increased Flexibility

- The ACR format for premiums and cost-sharing entries has been aligned with new Plan Benefits Package (PBP) form.

Other

- The ACR form for Part B-only plans has been de-linked from the Part A/B plan form.

Definitions

The following definitions are provided to help you understand the terminology used in these instructions.

Additional benefits include both health care benefits not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered benefits. Additional benefits are specified by the M+C organization and are offered to Medicare beneficiaries at no additional premium. Those benefits must be at least equal in value to the adjusted excess amount calculated in the ACR. An excess amount is created when the average payment rate exceeds the adjusted community rate (as reduced by the actuarial value of deductibles and coinsurance under Medicare Parts A and B). The excess amount is then adjusted for any contributions to—or withdrawals from—a stabilization fund. The remainder is the adjusted excess, which will be used to pay for benefits not covered by Medicare and/or to reduce charges otherwise allowed for Medicare-covered benefits. Additional benefits can be subject to cost sharing by plan enrollees and can be different for each M+C plan offered to Medicare beneficiaries.

Additional revenue is revenue collected—or expected to be collected—from charges for M+C plan benefit packages that exceed costs incurred or to be incurred. Additional revenue includes such things as revenue in excess of expenses directly related to a benefit package, profits, contributions to surplus, risk margins, risk reserves, and any other premium component not reflected in direct medical care or administrative costs.

The **adjusted community rate (ACR)** for a benefit usually is the base period cost adjusted to take into account the trend since the base period. For plans that

- had no Medicare enrollees and/or no non-Medicare enrollees in the base period, and/or
- expect to have no non-Medicare enrollees in the contract year,

the ACR is the M+C organization's best estimate of the plan's contract year cost.

The term "ACR" also refers to the forms on which ACRs are calculated and documented.

The **average payment rate (APR)** is the weighted average amount, on a per-member-per-month basis, that the M+C organization expects to receive from HCFA (without adjustment for such things as user fees, transactions involving a stabilization fund, etc.) for all Medicare beneficiaries electing the M+C plan being priced in an ACR. It does not include any bonus payments the M+C organization expects to receive due to offering the first M+C plan in a qualified county. Each year, HCFA will publish a rate book containing a payment rate for every county in the United States. The APR for an M+C plan will be based on the county payment rates in the M+C plan's service area. The county payment rates will be adjusted for demographics, risk, and other considerations, all at the H# level.

The **base period** is the most recently ended calendar year before the ACR is submitted.

The **basic benefit package** (or **basic benefits)** includes both Medicare-covered benefits (except hospice care) and additional benefits.

A **benefit** includes both health care services and health care items that M+C organizations provide to enrollees and for which the organizations incur direct costs.

The **contract year** is the 12-month period following the submission of the ACR to HCFA. Usually the contract year will begin on January 1. However, until CY 2002, new plans may begin on a different date.

Cost sharing includes co-payments, coinsurance, deductibles, and any other charge to enrollees on a per-benefit basis, regardless of who collects them.

An **excess amount** is the amount created, in a particular ACR proposal, when the average payment rate (APR) is greater than the ACR (less Medicare's deductibles and coinsurance).

Expected variation is an increase or decrease in the projected cost or revenue of an M+C plan reflecting factors not captured in the trends used to calculate the trended values. Such factors may include actual or projected changes in such items as benefit structure, utilization, technology, and demographics.

Worksheet D (Expected Variation) is provided for making those modifications. For example, if Medicare adds another benefit to covered benefits for the period of the ACR, the cost of that benefit would not be reflected in the base period costs for a given plan. Accordingly, an adjustment would be made to the ACR computation to allow it to more closely approximate the cost that would be incurred in the Medicare population during the ACR period. Worksheet D may be used in any situation when applying the trends to base period costs does not produce the expected contract year value.

H number (or H#) is an identification number that appears in a contract between HCFA and an M+C organization.

Health care components are the individual (or groups of) health care benefits or other activities on the lines (rows) of certain ACR worksheets—e.g., Worksheet B (Base Period Costs).

The **initial rate** is the rate, on a per-member per-year basis (for ease of computation, all entries are reduced to monthly amounts), to be charged to all non-Medicare enrollees that the M+C organization expects to have enrolled in the same type of M+C plan for the period covered by the ACR. The amount is computed using one of two methods:

- A community rating system.
- A weighted average aggregate premium basis.

M+C organizations offering a type of plan (for example, provider-sponsored organizations) that will not have an enrolled non-Medicare population will not have an initial rate.

Loss, for ACR purposes, is the amount by which the ACR (less Medicare's deductibles and coinsurance) exceeds the APR. Because losses are not passed through to the Medicare enrollees, they cannot affect the premium charged to Medicare beneficiaries. A loss shown on the ACR does not necessarily represent a financial statement loss.

An **M+C organization** is a public or private entity licensed by a state as a risk-bearing entity (with the exception of provider-sponsored organizations [PSOs] receiving waivers) and certified by HCFA as meeting the M+C contract requirements.

An **M+C plan** is health care coverage offered under a policy, contract, or plan by an M+C organization that includes a specific set of benefits offered at a uniform price to all Medicare beneficiaries residing in the M+C plan's service area. The benefits would include all Medicare-covered benefits (except hospice care) and additional benefits, and can include mandatory supplemental benefits. In addition, the M+C organization can offer optional supplemental benefits to be purchased at the option of the beneficiary. Multiple M+C plans can be offered within the service area of the M+C plan or M+C organization. Each M+C plan must be offered to all members at the same premium and cost-sharing levels approved for the plan. After 2001, M+C plans as approved remain in effect during an entire contract period and cannot be changed except for benefits required to be furnished because of changes in Medicare's coverage that are not considered to have resulted from a national coverage decision (NCD). (For more on NCDs, see 42 Code of Federal Regulations [CFR] 422.109.)

M+C plan types are coordinated care plans (these include health maintenance organization [HMO] plans, HMO plans with a point-of-service [POS] benefit, PSOs, and PPO plans); religious fraternal benefit plans; M+C MSAs; and M+C PFFS plans.

M+C service area means a geographic area approved by HCFA within which an eligible individual may enroll in a particular M+C plan offered by an M+C organization. For coordinated care plans and network medical savings account plans only, the service area also is the area within which there exists a network of providers that meets the access standards in 42 CFR 422.112. The service area also defines the area where a uniform benefit package is offered. In deciding whether to approve a service area proposed by an M+C organization for an M+C plan, HCFA considers the organization's non-Medicare service area for the type of plan in question (if applicable), community practices generally, whether the boundaries of the service area are discriminatory in effect, and—in the case of coordinated care and MSA plans—the adequacy of the provider network in the proposed service area.

Under the BBRA, each M+C plan can have a segmented service area. In the case of segmented service areas, all M+C rules regarding service areas, such as the rule on uniformity of premiums, apply to each segment. The BBRA also requires a separate ACR for each service area segment. For purposes of this instruction, whenever the term "service area" is used, it also refers to service area segments.

Mandatory supplemental benefits are benefits not covered by Medicare that beneficiaries must purchase as a condition of enrollment in a plan. Usually, those benefits are paid for by premiums

and/or cost sharing. Mandatory supplemental benefits can be different for each M+C plan offered by an M+C organization. M+C organizations must ensure that mandatory supplemental benefits are not used to discourage enrollment by any particular group of Medicare beneficiaries.

A **Medicare enrollee** or **M+C plan enrollee** is a Medicare beneficiary who has been identified on HCFA records—or is projected to be identified by the organization—as having elected the M+C plan being priced by an ACR proposal.

Non-Medicare enrollees are the enrollees that an M+C organization must consider in determining the base period collections and initial rate for an ACR. Specifically, in determining those values, an M+C organization must consider the actual or projected costs (as appropriate) of the same type of plan (e.g., coordinated care, PFFS, or MSA) and all service areas of the organization for the type of M+C plan being priced. Non-Medicare enrollees include any commercial enrollees, Medicaid enrollees, or certain Medicare beneficiaries such as those who are enrolled in a cost-contracting arrangement offered by an M+C organization (e.g., a health care prepayment plan [HCPP]). HCFA considers those Medicare beneficiaries to be non-Medicare enrollees of the M+C organization.

Any Medicare beneficiary who has been identified on HCFA records—or is projected to be identified by the organization—as having elected the M+C plan being priced by an ACR proposal cannot be treated as a non-Medicare enrollee. The 2 categories—Medicare enrollees and non-Medicare enrollees—are mutually exclusive.

Optional supplemental benefits are benefits not covered by Medicare that beneficiaries can choose to buy or to reject. Beneficiaries who choose such benefits pay for them directly, usually in the form of premiums and/or cost sharing. Those benefits can be grouped for marketing purposes only or offered individually to enrollees. They can be different for each M+C plan. An ACR must be computed for each optional supplemental benefit.

Premiums, for purposes of this document, include all other charges to the enrollees paid to the M+C organization or its designee (as distinct from the Part B premium paid to Medicare) that are not on a per-benefit basis.

A **stabilization fund** is a non-interest-bearing fund that HCFA will establish at your request to withhold a portion of your per capita payments. The amounts withheld are available to you for payment in subsequent contract periods to stabilize fluctuations in the availability of additional benefits you provide to your Medicare enrollees.

Statutory benefit categories are classifications of health care components for purposes of the ACR. They include **Medicare-covered benefits** and **additional benefits**, which constitute the basic benefits grouping defined in the Balanced Budget Act of 1997. They also include **mandatory supplemental benefits** and **optional supplemental benefits**, which constitute the supplemental benefits grouping defined in that act.

Trend usually includes actual or projected changes in items such as benefit structure, utilization, charges, or demographics. For purposes of the ACR, trend is a 2-year factor, calculated by Part

IB of Worksheet A (Cover Sheet), representing the percentage change between certain non-Medicare values for the base period and contract year. The trends are used in the ACR methodology to adjust base period costs of Medicare enrollees—where applicable—to produce contract year trended values for relevant health care components by statutory benefit category. The trended value, with any necessary adjustments (i.e., "expected variations"), is the estimated ACR value of each health care component for the contract year.

Worksheet A computes three trend values, one for each of the following: "Collections from Enrollees/Initial Rate," "Direct Medical Costs," and "Administration."

A **Trended Value** is the base year cost of a health care component that has been modified by one of the trends calculated in Part IB of Worksheet A.

General Instructions

M+C organizations must submit their annual renewal premium information (premium and M+C plan documentation) by July 1, 2000, covering the contract period January 1, 2001, through December 31, 2001. This same cycle will be used for all subsequent years. Annual ACRs with information for the next calendar year are due no later than July 1 of the then-current calendar year.

One ACR proposal must be submitted for each M+C plan that the M+C organization intends to market in the service area of each M+C plan. Organizations with both Part A/B Medicare enrollees and remaining Part B-only Medicare enrollees must have *separate* M+C plans for *each* of those two groups. A Medicare beneficiary with Medicare coverage only under Part B cannot elect an M+C plan after December 31, 1998. However, a Medicare beneficiary (with Part B coverage under Medicare) who was a Medicare enrollee of a Section 1876 contractor on December 31, 1998, shall be considered to be enrolled with that organization on January 1, 1999, if the organization had an M+C contract for providing benefits on the latter date. Health benefit coverage provided to such remaining Part B-only enrollees constitutes a separate M+C plan (which requires a separate ACR).

In order for an ACR proposal to be approved by HCFA in a timely manner, the proposal must be filed as early as possible, must be in a format acceptable to HCFA, and must contain backup data to support certain figures and computations. It is not unusual for HCFA's reviewer of an ACR proposal to request additional information or clarification of submitted data. And, HCFA reviewers may have to ask for certain information before completing their full review of an ACR. In either case, HCFA reviewers need a prompt response in order to meet related deadlines such as the printing schedule for *Medicare Compare*. The approval of an ACR proposal is delayed each time HCFA has to request additional documentation. To avoid unnecessary delays and speed up the review process, follow the guidelines listed below (and any supplemental guidelines that HCFA issues) when preparing your ACR proposal.

Certain ACR entries you make must be accompanied by adequate supporting data. If you do not have enough enrollment experience to develop data, you may use financial budgeting techniques that are generally acceptable throughout the health care industry.

Please observe the following guidelines to ensure timely review:

- Clearly show in the ACR proposal all cost sharing listed in the PBP for the M+C plan.
- List reinsurance (actual cost) and HCFA's user fees in the category of Administration.
- Use medical benefit categories (health care components) set forth on the lines of certain ACR worksheets. The Administration and Additional Revenue components must contain plan data when you submit your ACR.

  - With respect to Worksheet B only, you may group data for health care components—other than Point-of-Service (POS), Administration, and Additional Revenue—that your accounting system will not break out. If you must group the data for different health care components, explain which benefits were grouped and obtain HCFA's concurrence on the category groupings.

  - Data required for health care components on Worksheets C, and D cannot be grouped.

  - Data required for the statutory benefit categories (columns) on Worksheets B, C, and D, cannot be grouped.

- Organize all backup data by worksheet. Additional, detailed instructions for sending the ACR and supporting material to HCFA will be available under separate cover.

- Group medical benefits included in specific categories consistently from year to year.

- Your identification number (Medicare contract number) must be clearly displayed in the cover letter and in all subsequent correspondence with HCFA.

Accounting Considerations

Except as provided in the next paragraph, M+C organizations must have an adequate accounting system that is accrual based and uses generally accepted accounting principles to develop its ACR.

For organizations that are part of a government entity that uses a cash basis of accounting, ACR cost data developed on that basis is acceptable. However, only depreciation on capital assets, rather than the expenditure for the assets, is acceptable.

Relationship of the ACR to the Plan Benefit Package Form

M+C organizations must submit a PBP with each ACR. The two documents together constitute an ACRP for an M+C plan. The PBP worksheet will replace the Beneficiary Information Form (BIF) formerly required under the ACR proposal process. Unlike the ACR, the PBP exists only as an electronic document—there is no paper version of it. Instructions for completing the PBP worksheet are available from HCFA under separate cover.

The ACR uses 21 direct medical health care components (exclusive of Administration and Additional Revenue) on the lines of Worksheets B, C, D, and E (Part II). Entries for those components must be consistent with related entries on the PBP for the same plan. (EXCEPTION—Entries on Worksheet B that don't relate to optional supplemental benefits don't have to be consistent with the PBP categories if the organization has received approval from HCFA to group data for individual health care components on that worksheet.)

Relating the data in the two documents is relatively easy, because the PBP groupings of individual health care benefits have the same names as the ACR's health care components. For example, if your plan includes any of the preventive benefits that are shown under the PBP category called "Preventive Services" (category 14), you would include the costs for those benefits on the Preventive Services line of your ACR.

ACR Electronic Worksheets and Database

ACR forms are provided to you in Excel format. Both paper copies and electronic copies of the ACR forms, with all required backup material, must be submitted to HCFA by the due date. Electronic copies of each ACR worksheet are accessible through HCFA's Health Plan Management System (HPMS). HCFA will provide, under separate cover, detailed instructions pertaining to

- access to HPMS and related matters, and
- the submission of paper copies of the ACR and related back-up material.

The following sections explain how to fill out each individual worksheet in the ACR proposal. In addition to the instructions in this document, most electronic worksheets contain pop-up notes in many of the cells that provide *limited* on-line instructions for specific cells or groups of cells. Use the pushpin symbols at the worksheet's upper left corner to activate or deactivate the pop-up notes. Normally the notes are activated. When the notes are activated, move your cursor to a red triangle to view the notes for that cell.

Please note that certain entries described below are required. When you submit (upload) your ACR to HCFA via HPMS, the system will check for some of the required entries and will not permit an upload if any of that information is missing. To reduce the number of failed uploads, pre-upload validation software will be available for you to use before you submit your ACR. The validation software, which is separate from the ACR worksheets, will allow you to spot ACR errors such as missing required data. If you correct all the errors flagged by the validation software, your ACR workbook should be ready for a successful upload to HPMS. Use of the validation software is mandatory for your initial upload, and you must have Microsoft Access 97 to use it.

In addition, the electronic worksheets have built-in validation features that will prompt you to add or delete entries as appropriate. For example, cells highlighted in yellow signify a missing entry in that cell or in a linked cell. On the other hand, cells highlighted in red signify an unnecessary entry, perhaps one that belongs in another cell. In other examples, the worksheets will not allow negative entries or text entries where they are inappropriate.

Worksheet A—Cover Sheet

Part IA—Organization and Plan Data

The following paragraphs provide line-by-line instructions for Part IA of the worksheet. All line numbers refer to column a.

Line 1—Name of M+C Plan. On line 1, enter the name of the M+C plan being offered. This information must be provided.

Line 2—Organization Number. On line 2, enter the alphanumeric designation for the contract unique to this ACR proposal. The designation should begin with a capital P and include five Arabic numerals. Enter this number in the form of P#####. Please, include leading zeros. For example, to enter P00122, be sure to include all five numbers. Obtain this number from your contract with HCFA. You must enter it on line 2. Please do *not* enter the H# here.

Line 3—H #. Enter the H number for the plan on line 3. The designation should begin with a capital H and should include four Arabic numerals. Enter this number in the form of H####. Please include all leading zeros. Obtain this number from your contract. You must enter the H# on line 3.

Line 4—Plan ID. The plan ID is a designation, with a corresponding H#, that forms a unique identifier for the plan being priced in this ACR. Plan IDs contain 3 Arabic numerals. Except as indicated below, all plans under each H# are to be numbered consecutively in your initial upload, starting with 001. You must enter a plan ID on Worksheet A. Enter the same plan ID on line 4 that was used for the corresponding PBP. Please remember to enter all leading zeros. For example, enter 001 for plan number one.

M+C organizations will be assigning their own plan IDs for CY 2001. Please adhere to the following rules when assigning plan IDs. If your organization is offering the same plan in CY 2001 as it did in CY 2000, use the plan ID HCFA assigned to the plan in CY 2000. In this context, the term "same plan" refers to a plan that, for both CY 2000 and CY 2001,

- is of the same type (e.g., HMO),
- is offered to the same type of enrollee (e.g., Part B-only),
- covers substantially the same service area (i.e., has at least one common county), and
- has the same or different benefits, premiums, and cost sharing.

EXCEPTION—HCFA did not assign plan IDs to Part B-only plans in CY 2000. Therefore, organizations will choose unique plan IDs for *all* Part B-only plans in CY 2001.

REMINDER—If your CY 2001 plan reduces the previous year's service area (e.g., deletes an entire county) or changes the service area so that at least one payment area (e.g., county, parish) is reduced, call your plan manager to discuss the effects of the change on plan enrollees.

If an M+C plan offered in CY 2000 will be terminated by December 31, 2000, do not reuse that plan's ID until notified.

Line 5—Type of Plan. Enter the type of M+C plan, such as coordinated care plan, religious fraternal benefit plan, M+C MSA, or PFFS. You must provide this information.

REMINDER—A separate ACR proposal must be submitted for each M+C plan.

When completing this cell, select one of the following codes from the drop-down menu on the electronic worksheet:

- For coordinated care plans:

Health maintenance organizations	HMO
Health maintenance organizations with a point-of-service (POS) option	HMOPOS
Provider-sponsored organizations	PSO
Preferred provider organizations	PPO
Other	CCOTH

- Religious fraternal benefit plans — RFB
- For M+C private fee-for-service plans — PFFS
- For M+C MSA plans — MSA
- For other types — OTH

EXCEPTION— If you are using the ACR format for a non-M+C plan, select "Non-M+C" from the drop-down menu.

Line 6—Enrollee Type. If an ACR prices any type of plan covering enrollees eligible for both Part A and Part B of Medicare, choose "Part A/B" from the drop-down menu for this cell. If an ACR prices an HMO or HMOPOS type of plan covering enrollees eligible only for Part B, choose "Part B-only" from the drop-down menu.

While, nearly all M+C enrollees are eligible for both Part A and Part B of Medicare, some are eligible only for Part B benefits. HCFA regards plans serving Part B-only enrollees as separate from plans serving Part A/B enrollees. Therefore, ACRs that price plans serving Part B-only enrollees must be separate from ACRs that price plans serving Part A/B enrollees.

Line 7—ACR Contract Year. This cell is pre-loaded with the calendar year that contains the ending date for this ACR. The cell is locked. Except for new applicants, the period covered by an ACR must include at least 12 months and start on the first day of the calendar year (e.g., January 1, 2001) and end on the last day of the calendar year. Until CY 2002, new applicants may start on a different date. They should contact the plan manager HCFA assigned to their organization in order to obtain the starting date for the new plan.

Line 8—Average Payment Rate. The worksheet enters on line 8 the APR computed by your M+C organization on Worksheet A1. The cell is linked to Worksheet A1 and therefore is locked. The APR is the amount the M+C organization estimates that HCFA will pay (except for certain withheld amounts such as the information campaign user fee) in dollars and cents per member per month during the period covered by the ACR for each Medicare beneficiary electing the M+C plan being priced.

Line 9—Contribution to Stabilization Fund. Enter on line 9 the amount of contributions to your stabilization fund in dollars and cents (2 decimal places) per member per month. That is the amount your M+C organization elects to contribute to its stabilization fund as part of additional benefits or in lieu of offering additional benefits during the period covered by the ACR. Contributions must be entered as a positive number. If the organization wants to withdraw an amount per Medicare member per month to stabilize benefits in the period of the ACR, enter a negative number. The entry of a number other than zero in this cell will directly effect HCFA's payment to you.

Line 10—Number of Years to Hold Stabilization Fund. Enter the number of years, after the end of the period covered by the ACR, for which you want HCFA to hold the amount you contribute to a stabilization fund. Amounts not withdrawn by the end of this period will be returned to Medicare. Please do not enter a value in this cell if your organization is not contributing to a stabilization fund during the contract year.

Line 11—Medicare Deductible and Coinsurance. The actuarial value of Medicare's deductible and coinsurance amounts in dollars and cents per member per month is provided by HCFA's Office of the Actuary and will be entered here automatically. The amount will be the correct amount for the enrollee type you choose for line 6 above.

Line 12—Medicare Psychiatric Co-Payment. The Medicare psychiatric co-payment amount also is provided by HCFA's Office of the Actuary in dollars and cents per member per month. It will be entered here automatically. The amount entered will be the same for all enrollee types.

Line 13—Medicare Enrollment Capacity. Enter Medicare enrollment capacity, which is the M+C organization's capacity allocated to Medicare beneficiaries during the contract period. Specifically, it is the total number of Medicare enrollees to which the M+C organization estimates it could reasonably provide the quantity and quality of benefits (with sufficient access) offered by the M+C plan during the period covered by the ACR. A value must be entered on this line unless the organization has no capacity limit. When entering a value, please enter a whole number. Enter "unlimited" on line 13 if there is no capacity limit.

Line 14—Non-Medicare Enrollment Capacity. Enter the capacity allocated to non-Medicare enrollees during the contract period. This is the total number of non-Medicare enrollees to which the M+C organization estimates it could reasonably provide the quantity and quality of benefits (with sufficient access) offered by same the type of plan being priced in an ACR for the period covered by the ACR. A value must be entered on this line unless the organization has no capacity limit. When entering a value, please enter a whole number. Enter "unlimited" on line 14 if there is no capacity limit.

Line 15—Projected Average Monthly Medicare Membership. Enter the average number of Medicare members (on a monthly basis for the entire contract period) that the M+C organization expects to be enrolled in the M+C plan being priced in this ACR. Please enter a whole number.

Line 16—Projected Avg. Monthly Non-Medicare Membership. Enter the average number of non-Medicare members (on a monthly basis for the entire contract period) expected to be enrolled in all benefit packages offered by your organization through the type of M+C plan being priced in this ACR. Please enter a whole number.

Line 17—Delegation of Authority to Submit Certain Changes. A certification (at the bottom of Worksheet A) must be completed for each ACR. If an organization changes its ACR after the initial submission to HCFA, the certification must be re-signed, re-dated, and submitted with the changed ACR unless you select "yes" from the drop-down menu for line 17. In that case, the contact person named on line 6 of Part IB will be authorized to submit to HCFA the types of changes described below *without* submitting a new certification with the revised ACR:

- On Worksheet A—
  - Part IA, lines 13, 14,15, and 16
  - Part IB lines 5, 7, and 8.
- On Worksheets A1, B, B1, C, and D—
  - Any unlocked cell, as long as the change does not affect Worksheet A of the most recently certified ACR for your plan.

Part IB—Organization and Plan Data

The following paragraphs provide line-by-line instructions for Part IB of the worksheet.

Non-Medicare Information: Column a—Base Period.

Part IB, lines 1 through 3, of the worksheet will accept positive entries with many decimal places. If data are entered on any one of lines 1, 2, or 3, data must be entered on all three lines.

Line 1—Collections from Enrollees. M+C organizations that had non-Medicare members in the base period must enter base period collections, on an accrual basis, from non-Medicare enrollees

on line 1 in dollars and cents per member per month. Otherwise, leave line 1 (and lines 2 and 3) of column a blank.

Base period collections are the average amount per member per month collected (premiums and cost sharing) in the base period from all non-Medicare enrollees for all benefit packages offered by an M+C organization under the type of M+C plan being priced in an ACR. Report collections from enrollees under generally accepted accounting principles (GAAP). The collections from enrollees should include all cost sharing charged to non-Medicare enrollees under the specific type of plan, regardless of who collected it. The collections from enrollees contain three components that represent

- direct medical care costs,
- administration costs, and
- revenue received in excess of the costs actually incurred in delivering the benefits contained in all of your non-Medicare benefits packages offered under this type of M+C plan (called "additional revenue").

Line 2—Direct Medical Care. Enter on line 2 direct medical care in dollars and cents per member per month. Direct medical care represents the cost of providing medical care net of administration and additional revenue.

Line 3—Administration. Enter on line 3 administration costs in dollars and cents per member per month. The entry represents the costs of administration of the type of M+C plan being priced. Examples of administration costs are occupancy, compensation of employees, sales and marketing, medical management, and other expenses. Reinsurance (actual cost) and user fees are to be included in the costs of administration.

Line 4—Additional Revenue. The worksheet calculates additional revenue automatically. The cell contains the result of subtracting the sum of line 2 and line 3 from line 1. The worksheet will permit negative values for additional revenue. Additional revenue represents the revenue properly accrued beyond the costs actually incurred. The cell is locked.

Non-Medicare Information: Column b—Contract Period.

Part IB, lines 1 through 3, of the worksheet will accept positive entries with many decimal places. If data are entered on any one of lines 1, 2, or 3, data must be entered on all three lines.

Line 1—Initial Rate. M+C organizations that expect to have non-Medicare members in the contract year must enter the initial rate for that period on line 1 in dollars and cents per member per month. Otherwise, leave line 1 (and lines 2 and 3) of column b blank.

The initial rate is an amount your organization calculates using a community rating system or a weighted average aggregate premium method. It represents the average amount per member per month expected to be collected (premiums and cost sharing) from all non-Medicare enrollees for

all benefit packages offered by an M+C organization under this type of M+C plan during the period covered by this ACR proposal. The initial rate should include all cost sharing to be charged to non-Medicare enrollees. It contains three components that represent expected

- direct medical care costs,
- administration costs, and
- revenue to be received in excess of the costs actually incurred in delivering the benefits contained in all of your non-Medicare benefits packages offered under this type of M+C plan (additional revenue).

Line 2—Direct Medical Care. Enter on line 2 direct medical care in dollars and cents per member per month. The entry represents the expected cost of providing medical care net of administration and additional revenue.

Line 3—Administration. Enter on line 3 administration costs in dollars and cents per member per month. The entry represents the expected costs of administration of the type of M+C plan being priced. Examples of administration costs are occupancy, compensation of employees, sales and marketing, medical management, and other expenses. Reinsurance (actual cost) and user fees are to be included in the costs of administration.

Line 4—Additional Revenue. The worksheet calculates additional revenue automatically. The cell contains the result of subtracting the sum of line 2 and line 3 from line 1. The worksheet will permit negative values for additional revenue. The entry represents the expected revenue properly accrued beyond the expected costs. The cell is locked.

Non-Medicare Information: Column c—Two-Year Trend.

Lines 1 through 4—Trend Calculation. The worksheet automatically calculates a trend value on lines 1 through 3 of column c. The trend is the two-year change between the base period and the contract year. In other words, the trend values are not annualized. The trend values are applied to relevant base year costs by formulas in Worksheet D to calculate trended values for individual health care components.

If there are any blank entries on line 1, 2, or 3 of column a or column b, "No trend" will appear in lines 1 through 3 of column c. In that case, no trended values are computed, and you must enter your best estimates of the costs of individual health care components in the appropriate expected variation cells of Worksheet D.

A trend is never calculated for line 4 (Additional Revenue). As described above, additional revenues are not projected separately, as are other health care components. Instead, contract year values for additional revenues are calculated as residuals on Worksheet D.

The cells for lines 1 through 4 in column c are locked.

Organization Name and Plan Contact.

Lines 5 through 8, in Part IB of the worksheet, will accept text entries.

Line 5—Name of M+C Organization. Enter the name of the M+C organization submitting the plan being priced.

Line 6—Plan Contact Person and Position. Enter the name and position title of the person whom HCFA should contact for answers to questions about the information on the ACR.

Line 7—Plan Contact Person Telephone Number and Area Code. Please enter the telephone number (with area code) of the person listed on line 6. Enter all ten digits without parentheses or dashes.

Line 8—Plan Contact Person E-mail Address. Please enter the e-mail address of the person listed on line 6. If the person has no e-mail service, enter "None"

Part II—M+C MSA Supplemental Data

M+C organizations offering an M+C MSA plan are not required to complete all ACR worksheets to price that type of M+C plan. However, such organizations must furnish certain information about MSAs on ACR worksheets. In addition to describing the benefits contained in the plan as reported on the PBP form, you must furnish information requested for this worksheet in Part IA (lines 1 through 6, and 13 through 17), Part IB (lines 5 through 8), Part II, and the certification. MSAs also must submit Worksheet A1 and the PBP. Non-network MSA plans should contact the plan manager assigned by HCFA for further directions.

The following paragraphs provide line-by-line instructions for Part II of the worksheet. All line numbers refer to column a.

Line 1. Enter the annual deductible in dollars and cents per member for the M+C MSA plan. Obtain the maximum allowable deductible amount from HCFA's Office of the Actuary.

Line 2. Enter the M+C MSA monthly premium per member in dollars and cents. If this amount is less than the monthly county capitation rate, the difference is the monthly amount that HCFA will deposit in the M+C MSA plan enrollee's MSA account. This difference for each M+C plan enrollee will be deducted from your monthly payment. The amount deposited in the enrollee's account will equal the monthly difference times the number of months during the contract year for which the Medicare beneficiary has elected the plan. HCFA will deposit the full amount in the enrollee's MSA account at the time of the initial election.

Line 3. Enter the M+C MSA monthly supplemental premium per member (if any) in dollars and cents.

Line 4. Enter the actuarial value of any cost sharing per member per month on supplemental benefits, if offered, in dollars and cents.

Line 5. Enter (in dollars and cents) the monthly average of amounts collected per member in the most recent calendar year from M+C plan enrollees electing this M+C plan.

Part III—Summary of M+C Enrollee Charges from Worksheet C

Part III is a summary of M+C enrollee charges. The data are imported from Worksheet C. No entries are required. The cells are locked. Note that the total premium for optional supplemental benefits is merely the sum of the premiums for each item—it does not represent a "high option" for the plan.

If "MSA" appears on line 5 of Part IA, then "MSA" will appear in all cells of Part III.

Certification Signatures

The chief executive officer, the chief financial officer, and the person in charge of marketing must all sign the certification at the bottom of Worksheet A. If the M+C organization will be submitting more than one ACR per type of M+C plan, all those ACRs should be submitted together with only one set of certification signatures. A set of certification signatures must be completed for each type of M+C plan offered by the M+C organization.

In general, certification signatures are required for the initial ACR and any modified ACRs submitted after the initial one. However, certification signatures may be omitted for modified ACRs under certain circumstances. See the instructions for Part IA, line 17.

Please type the name of each official in the box above the corresponding position title.

Worksheet A1—Service Area and Estimate of Annual Payment Rate

Worksheet A1 is provided for two purposes: to identify the service area of the M+C plan being priced in this ACR, and to calculate the plan's APR. Worksheet A1 must be completed for all plan types, including MSAs.

The APR calculation in this worksheet is intended to simplify the ACR process. Most cells requiring data collected or produced automatically by HCFA show the correct values corresponding to the state-county codes you entered in column a. If your organization can accept the resulting APR calculation without any plan-level adjustments in column j, then you will not have to submit any material with your ACR to substantiate the APR. If your organization needs to make plan-level adjustments in column j, please submit supporting material with your ACR to substantiate the adjustments.

The worksheet calculates the plan's CY 2001 APR by first calculating an APR for each county in the service area. Plan-level adjustments, if any, affect individual county APRs. Next, the worksheet calculates the plan APR per member per month (PMPM) as an average of total payments for all counties, weighted by plan membership.

The formulas for the calculations are as follows:

APR by County

$$\left(\frac{AMP2000_{Cn}}{CMP2000_{Cn}} \times CMP2001_{Cn} \times \left[1+\left(\left(\frac{RF2001-RF2000}{RF2000}\right)\times 0.1\right)\right]\right) - PLA = CAPR2001_{Cn}$$

Where:

- AMP2000 is the CY 2000 actual monthly payment for a county in the plan ($ PMPM)
- CMP2000 is HCFA's CY 2000 county payment rate for a county in the plan ($ PMPM)
- CMP2001 is HCFA's CY 2001 county payment rate for a county in the plan ($ PMPM)
- RF2000 is the HCFA-calculated CY 2000 risk factor for the relevant H#
- RF2001 is the HCFA-calculated CY 2001 risk factor for the relevant H#. (However, it can be replaced with a different value at the option of the organization.)
- PLA is the plan-level adjustment reflecting any modifications that M+C organizations wish to make to individual county APR calculations ($ PMPM).
- CAPR2001 is the average payment rate for a county in the plan ($ PMPM).
- 0.1 is the risk weight in the 90/10 risk adjustment methodology for CY 2001.
- Cn is the "nth" county in the plan's service area.

APR for the Plan

$$\frac{\sum_{C1}^{Cn}\left(CAPR2001 \times EAM\,2001\right)}{\sum_{C1}^{Cn} EAM\,2001} = APR2001$$

Where:

- CAPR2001 is the average payment rate for a county in the plan ($ PMPM).
- EAM2001 is the CY 2001 estimated average plan membership for a county in the plan.
- APR2001 is the average payment rate for the plan ($ PMPM).
- C1 is the first county and Cn is the nth county of the plan's service area.

The following sections provide detailed instructions for completing Worksheet A1.

The worksheet automatically copies the **Name of M+C Plan, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Part I—Rate of Change in H# Risk Factors

Enter on the first line your CY 2000 risk factor for the plan being priced in an ACR. If you do not have a CY 2000 risk factor for your plan, enter 1 (one) on the first line. An entry of 1 (one) signifies that the risk factor for plans under the H# is the same as the risk factor for the overall Medicare population. The worksheet will prohibit entries that are less than or equal to zero in this section and will trigger a dialogue box to prompt a correction. Do *not* leave the cell blank.

Enter on the second line the CY 2001 risk factor for the plan being priced in an ACR. Do *not* leave the cell blank, enter zero, or enter a negative number.

The third line automatically calculates the percentage change between the CY 2000 and CY 2001 risk factors entered on the first and second lines respectively. That cell is locked; users need not make an entry. An error message and a color change from white to red indicate that one or both of the preceding lines are blank or contain a number less than or equal to zero.

Part II—Calculation of Plan Annual Payment Rate (APR)

Part II displays the CY 2001 plan APR and other values automatically calculated from the data in Part III. All the cells in Part II are locked; users need not make any entries.

The values in Part II are defined as follows:

The **Number of Counties in this Plan** is the sum of the non-blank cells in Part III, column a.

The **CY 2001 Total Estimated Membership** is the sum of the entries in Part III, column l.

The **CY 2001 Total Estimated Payments ($ PMPM)** is the sum of the estimated total payment values by county in Part III, column m.

The **CY 2001 Estimated APR ($ PMPM)** is the average of county APRs in Part III, column k, weighted by county membership.

Part III—Plan Service Area and Calculation of APR by County

Column a—State-County Codes. Enter, in as many cells as needed, the Social Security Administration's (SSA's) state and county codes that define the M+C service area for the M+C plan being priced in this ACR. The service area reported will be compared to HCFA records. Enter each code in the form of ##### (the two-digit state code, followed by the three-digit county code). Please enter any leading zeros (e.g., the 0 in code 01234) so that you have a correct, 5-digit code. You can enter up to 100 state-county codes on the spreadsheet. If your plan has more than 100 counties, contact HCFA for help completing Worksheet A1.

If you enter a non-valid state-county code (e.g., too few digits, too many digits, a code not used by SSA), "N/A" will appear on the same line in columns b, d, e, f, g, i, k, and m. Also, a dialogue box will appear with an explanation of the error. You will have to click on "retry" or "cancel" to continue with the worksheet, but ultimately the worksheet will not allow the incorrect code.

If the plan service area has more than one county, do not leave any blank cells between the first and last state-county codes in column a. If you try to type a state-county code in a cell below a blank cell, an error message will appear. To eliminate the error message, enter a valid state-county code in the cell above the one that contains the error message.

If you enter the same state-county code twice, the first cell of the two cells (e.g., the cell with the smallest line number) will turn red to prompt you to delete the second entry.

Contact HCFA if you are unable to enter a valid state-county code in column a.

Column b—County Name. The worksheet will enter the county name that corresponds to the state-county code that you enter on the same line in column a. The cells are locked; users need make no entries. Contact HCFA if the county name does not appear. The county name may help users to spot errors in their state-county code entries.

As stated above, you have entered a non-valid state-county code in column a if "N/A" appears in on the corresponding line of column b.

Column c—CY 2000 Actual Monthly Payment Rate ($ PMPM). Enter the actual monthly payment rate in CY 2000 for each county in the service area. The actual monthly payment rates can be found in HCFA's CY 2000 demographic report for your H#. You can enter any positive numeric value as well as zero in column c. If you enter a negative value, an error message will prompt you to correct it.

Column d—HCFA's Estimated County Payment Rate for CY 2000 ($ PMPM). The worksheet will automatically enter HCFA's estimated county payment rate for CY 2000 corresponding to each county in the plan service area. The cells are locked; users need make no entries. "N/A" signifies a non-valid state-county code in column a.

Column e displays the result of dividing column c by column d. The cells are locked; users need make no entries.

Column f—HCFA's Estimated County Payment Rate for CY 2001 ($ PMPM). The worksheet will automatically enter HCFA's estimated county payment rate for CY 2001 corresponding to each county in the plan service area. The cells are locked; users need make no entries. "N/A" signifies a non-valid state-county code in column a.

Column g—CY 2001 Estimated County APR Before Risk Adjustments ($ PMPM). The worksheet will display the product of the values on the same lines of column e and column f, which is the CY 2001 estimated county APR before risk adjustments. The cells are locked; users need make no entries.

Column h—% Change in Risk Factor. The worksheet will automatically enter the % change in the risk factor from Part I of this worksheet. The cells are locked; users need make no entries.

Column i—CY 2001 Estimated County APR with Risk Adjustments ($ PMPM). The worksheet will display the result of adjusting each value in column g by 10% of the change in the risk factor in column h for each respective line. The cells are locked; users need make no entries.

Column j—Plan-Level Adjustment ($ PMPM). Enter any adjustment needed to make the county APR in column k consistent with your organization's calculations. You can enter both positive and negative numeric values in column j. Even though negative entries are permitted, the worksheet will not allow you to enter a negative amount large enough to make the values negative in the corresponding line of column k.

If not made elsewhere (e.g., in column c), include in column j adjustments to add back items that HCFA withheld from your CY 2000 payments. Examples of such items are the information campaign user fee and the end stage renal dialysis network fee. Use the appropriate CY 2001 amounts for such adjustments.

Please include, with the paper copy of your ACR, a detailed written justification for every adjustment in column j.

Column k—Estimated County APR for CY 2001 ($ PMPM). The worksheet displays the sum of column i and column j for each respective line. The cells are locked; users need make no entries.

Column l—CY 2001 Estimated Average Membership. Enter the projected average membership in CY 2001 for each county in the plan's service area. You can enter any positive

whole number or zero in column l. Members can be enrolled in only one M+C plan at a time; therefore, if the organization has multiple plans in a county, ensure that membership estimates for all plans in a given county are mutually exclusive. If you enter a negative value, an error message will prompt you to correct it.

Column m—CY 2001 Estimated Total Payment ($ PMPM). The worksheet displays the product of column k and column l for each respective line. The cells are locked; users need make no entries.

Printing Worksheet A1

The "Print Worksheet" and "Print Preview" buttons in the upper right-hand corner of the worksheet will help you print the worksheet. Click on the Print Worksheet button to print the worksheet. Click on the Print Preview button for a preview of the worksheet, as it will be printed.

Worksheet B—Base Period Costs per Member-Month

Worksheet B reflects the base period data to be used for calculating the contract year costs of individual health care components. It reports information reflecting the total Medicare enrollee costs for the base period. The base period is the most recently ended calendar year before the ACR is submitted. For example, the base period is calendar year 1999 for ACR proposals submitted in calendar year 2000 for CY 2001. Record on this worksheet Medicare revenue and costs actually incurred during the base period. EXCEPTION—As noted later on, coordination of benefits (COB) amounts are not necessarily actual collections.

No Grouping of Statutory Benefit Categories

To make the contract year ACR as accurate as possible, display Medicare enrollee revenue and costs for the base period in the column that reflects the statutory classification (i.e., Medicare-covered benefits, additional benefits, mandatory supplemental benefits, or optional supplemental benefits) in the PBP for the contract year plan. (For more on the previous point, see the instructions for lines 1 through 25.) This information will be used as the basis for calculating the amount HCFA will allow an M+C organization to charge Medicare enrollees for an M+C plan.

Grouping of Health Care Components

Not all health care components (lines) need be used, except for Direct Medical Care, Administration, and Additional Revenue (and POS, if the plan being priced is an HMOPOS). The categories you can use will depend on your accounting system. If you group health care components, obtain HCFA's concurrence on the component groupings before the ACR due date of July 1. Your accounting system must be able to produce cost figures consistent with the ACR format, as completed, in a manner that may be audited. Include, with your ACR, a document showing the benefits that have been grouped and the health care components to which they were assigned.

Please make the content of each health care component on Worksheet B consistent with the classification used in the PBP, unless you have approval to group health care component data on the worksheet.

EXCEPTION—Under no circumstances can the costs of individual optional supplemental benefits be grouped on Worksheet B. Displaying them separately on Worksheet B will allow the related trended values to be shown separately on Worksheet D. That in turn will allow the ACR forms to price the optional supplemental benefits separately on Worksheet E Part II by health care component, as required by Federal regulations.

Accrual Accounting and Related Considerations

The accounting system used to report base period entries should be accrual-based (an exception to the accrual method of accounting may be approved for certain governmental organizations).

Worksheet B should include only entries properly accrued to the base period and those entries should track to certified financial statements for that period. Worksheet B should also include any corrections needed to the certified financial data if the changes were made within 75 days after the end of the base period. Corrections made after the 75-day period should be reported on Worksheet D.

The method used in your accounting system to determine the cost per member-month for Medicare enrollees must be the same method used to determine the cost per member-month for non-Medicare enrollees, and the costs allocated to each category must represent a fair distribution of costs. Include on Worksheet B only those administration costs that bear a significant relationship to the M+C plan elected by Medicare enrollees.

The same accounting methods should be used for all columns of the worksheet.

Format of Base Period Entries

Worksheet B will allow users to make entries using up to two decimal places except for line 30, which requires whole numbers, and the cells for the begin and end dates of the base period, which require a date format. The worksheet will not allow text entries (e.g., "N/A"), nor will it allow negative entries except on COB and additional revenue lines. Error messages will prompt you to correct entries with the wrong format.

Line-by-Line Instructions

The following paragraphs provide line-by-line instructions for completing Worksheet B.

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A. If "select choice" or "enter data" appears in any of these cells, make the correct entry on the corresponding cell of Worksheet A.

Begin date. Enter the beginning date of the base period in date format (mm/dd/yyyy).

End date. Enter the end date of the base period in date format (mm/dd/yyyy).

When an M+C organization offers a collection of benefits with a common theme, such as a continuation package or a visitor program, the cost of the benefits must be broken out and shown under the correct health care component (except where HCFA has approved grouping, as discussed above). In any event, the cost for each health care component must be shown under the correct statutory category or categories.

EXCEPTION—If an M+C organization includes a POS benefit in a plan, the benefit must be priced separately and all of the direct medical costs must be included on line 19 (POS).

Lines 1 through 19.

Column a: On lines 1 through 19 of column a, the worksheet will enter the sum of the amounts on corresponding lines in columns b, c, d, and e. The cells are locked; users need make no entries.

In **columns b, c, d, and e,** record the correct cost data for each type of benefit, based on whether the benefit is Medicare-covered, an additional benefit, a mandatory supplemental benefit, or an optional supplemental benefit. For lines 1 through 18 of column b and lines 1 through 19 of columns c, d, and e, if the benefit *will* be offered in the contract year, enter the base period data in the column under which the benefit would be classified (Medicare-covered benefits, additional benefits, mandatory supplemental benefits, or optional supplemental benefits) for the contract year plan. If the benefit will *not* be offered in the contract year, enter the base period data in the column under which the benefit was classified for the base period plan *and* make a corresponding adjustment in Worksheet D. The following table may help to illustrate the application of this point.

Case	Statutory Benefit Category in BIF for Base Period (1999)	Statutory Benefit Category in PBP for Contract Year (2001)	Statutory Benefit Category for CY 2001 ACR Costs on Worksheet B	Adjustment on CY 2001 ACR Worksheet D
Benefit in new statutory benefit category in contract year	Optional supplemental benefits	Mandatory supplemental benefits	Mandatory supplemental benefits	None
Benefit in same statutory benefit category in base and contract years	Optional supplemental benefits	Optional supplemental benefits	Optional supplemental benefits	None
Base year benefit dropped in contract year	Optional supplemental benefits	None—not offered in CY 2001	Optional supplemental benefits	Enter an amount equal to trended value but with a negative sign
New benefit for contract year	None—the benefit was not offered in the base period.	Optional supplemental benefits	Do not show costs on Worksheet B, because the benefit was not offered in the base period.	Provide your best estimate of the cost of the benefit. Show the cost as an optional supplemental benefit.

NOTE—When entering the offsets described in the table on Worksheet D, be sure to enter on lines 23 and 24 of that worksheet any related offsets to the costs of administration and additional revenue.

If an additional or supplemental benefit is an extension of a Medicare-covered benefit (for example, the benefit allows more hospital days than are covered under Medicare), record the Medicare-covered amount under column b, and record the difference between the total benefit

and the Medicare-covered amount, as appropriate, under additional benefits, mandatory supplemental benefits, or optional supplemental benefits.

42 CFR 422.105 states that POS benefits can be offered as an additional benefit, a mandatory supplemental benefit, or an optional supplemental benefit. Accordingly, POS benefits cannot be offered as a Medicare-covered benefit. As a result, line 19 (POS) is blocked out under the Medicare-covered category (column b). Line 19 relates only to POS benefits. POS costs must be aggregated on line 19 of the appropriate column. Furthermore, POS benefits must be approved by HCFA before it can approve an ACR containing them.

Lines 20 and 21—COB. Please note that column b, lines 20 and 21, and columns c through f, line 21, should reflect the coordination of benefits (COB) amount that the M+C organization was entitled to collect (regardless of the actual amount collected) when Medicare was the secondary payer for a given health care benefit. The COB amount to which M+C organizations are entitled in such instances is based on actual liabilities of other insurance coverage that Medicare enrollees have. Medicare costs on lines 20 and 21 (COB) should be entered in the same column (i.e., column b, c, d, or e) that you used to classify the costs of the base period benefits to which the COB payments are related.

Line 22 displays the total of the preceding lines in each column of the worksheet.

Lines 23 and 24—Administration and Additional Revenue. Administration, **line 23**, and Additional Revenue, **line 24**, show the costs of administration actually incurred and additional revenue collected and properly accrued in accord with generally accepted accounting principles. Base period Medicare costs for administration and additional revenue should be shown in the same column (i.e., column b, c, d, or e) that you use to classify the costs of the base period benefits to which those entries are related. Some M+C organizations may not be able to differentiate the costs of administration to be entered in columns b through e. In those situations, the organization must identify the cost of administration incurred for Medicare enrollees electing this M+C plan. Once that amount is identified, allocate it to columns b through e using the ratio of columns b, c, d, and e, line 22, taken individually, to column a, line 22. A similar computation may be used for line 24. M+C organizations are required to identify administration costs and additional revenue for optional supplemental benefits (column e).

Line 25 displays the total of line 22 through line 24.

Lines 29 and 30.

EXCEPTION—Medicare entries for lines 29 and 30 will *not* be handled as described above in the instructions for lines 1 through 24. Instead, enter Medicare data on lines 29 and 30 in the column (i.e., column b, c, d, or e) that correctly classifies the entry for the base period. For example, all amounts collected for additional benefits in the base year should be shown on line 29 in that column (column c) of Worksheet B.

Line 29—Amounts collected. Enter in columns b, c, d, and e the per-member per-month amounts (in dollars and cents) of total revenue collected in the form of cost sharing and premiums

from all Medicare enrollees electing the M+C plan for Medicare-covered benefits, additional benefits, mandatory supplemental benefits and optional supplemental benefits, respectively. Amounts should be reported on an accrual basis and should include all sums collected from enrollees by the M+C organization and/or any provider that furnished a benefit covered by the M+C plan. Do *not* include on line 29 any amounts collected from HCFA.

Line 30—Enrolled member-months. Enter in column b the total number of enrolled-member-months for the plan during the base period. One member-month is counted for each month during which a person is enrolled in the plan.

Worksheet B1—Base Period Financial Data

Worksheet B1 provides HCFA with key financial information about M+C organizations. The indicators on the worksheet will be used to measure an organization's performance and financial health over several periods and against other M+C organizations with similar characteristics (e.g., size, geographic location). The indicators alone do not necessarily signal whether an M+C organization is going to go insolvent; they simply provide a way of evaluating the organization's financial condition and performance at a point in time. This worksheet also will be used for desk review purposes.

NOTE—Even though Worksheet B1 data are compiled at the M+C organization level rather than at the plan level, please fill out Worksheet B1 in every Excel workbook you submit to HCFA. Also, note that the worksheet will accept only numeric values in the cells requiring entries. If you make non-numeric entries, an error message will appear to prompt you to enter a numeric value.

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Column a—Prior Period. The prior period is the calendar year before the beginning of the base period. The base period is the most recently ended calendar year before this ACR proposal is due. In other words, if this ACR proposal is due in 2000, the prior period is calendar year 1998. Enter the values for lines 6-17 to 2 decimal places.

Column b—Base Period. Enter the values for lines 6-17 to 2 decimal places.

Column c—Change. The change is calculated automatically and represents base period values less prior year values. Users need make no entries; all the cells in the column are locked.

Column d—% Change. The percent change is calculated automatically; it represents the change value divided by the prior period value. Users need make no entries; all the cells in this column are locked.

Use of Indicators

Line 1—Net worth (dollars). Net worth equals total assets minus total unsubordinated liabilities. This ratio shows an organization's excess of assets over its liabilities. It indicates the value of the firm with respect to equity.

Line 2—Total revenue (dollars). This figure reveals how much revenue the organization generated from all of its business plus investment, interest, and aggregate (miscellaneous) income.

Line 3—Operating revenue (dollars). This figure reveals how much revenue the organization generated from its primary lines of business.

Line 4—Operating profit or loss (dollars). This value indicates the amount of money the organization has after covering its direct medical and administrative expenses for a particular period. It reveals how well the organization is covering all of its costs of operations.

Line 5—Net profit or loss (dollars). This value is simply the operating surplus (or deficit) after considering taxes and extraordinary costs.

Line 6—Medical expense ratio. This ratio reveals the percentage of the organization's premium revenue needed to meet its direct medical costs for a particular period.

Line 7—Administrative expense ratio. This ratio reveals the percentage of the organization's premium revenue needed to meet its administrative costs for a particular period.

Line 8—Overall expense ratio. This ratio reveals the percentage of the organization's premium revenue needed to meet its direct medical and administrative costs for a particular period.

Line 9—Operating profit margin. This ratio reveals the percentage return the organization achieved on its operations for a particular period. It measures how effectively an organization is performing with respect to its ability to cover its fixed and variable expenses. The higher the ratio, the better is an organization's financial performance.

Line 10—Overall profit margin. This ratio reveals the percentage return the organization achieved on its operations for a particular period when taxes and any extraordinary expenses are taken into account. It measures how effectively an organization is performing with respect to its ability to cover its fixed and variable expenses as well its tax liability. The higher the ratio, the better is an organization's financial performance.

Line 11—Debt-to-service ratio. This ratio indicates how effectively the organization is meeting its annual principal and interest charges on its outstanding debt.

Line 12—Current ratio. This ratio measures an organization's ability to meet its short-term liabilities with its current base of short-term assets. The ratio is short-term assets divided by short-term liabilities. Specifically, an organization must be able to convert its short-term assets such as investments and premium receivables to cash to cover its liabilities as they come due. A thumbnail standard for a desirable current ratio is a ratio greater than 1-to-1 (meaning that an organization has short-term assets equal to or greater than short-term liabilities). However, a current ratio of less than 1-to-1 does not imply that an organization cannot meet its obligations as they come due. See line 13 below for a more extensive explanation.

Line 13—The sum of current assets and long-term bonds divided by current liabilities. This ratio takes into account the fact that many organizations move a good deal of their spare cash to longer-term assets, such as Treasury and blue chip corporate bonds. Because organizations receive cash (premiums) up front, they have a period of time to invest in longer-term assets such as Treasury bonds, which generally offer a greater return than shorter-term instruments such as certificates of deposit (CDs). Therefore, many organizations move their spare cash out of the short-term investments to take advantage of the higher return.

However, this has the effect of making an organization appear—from the current ratio analysis—as if it did not have adequate resources to meet short-term obligations. Thus, as the user of the financial statements, we must recognize that these longer-term bonds are valued at the current market price and are extremely liquid. They can be converted to cash to cover short-term obligations as easily as the short-term investments and thus should be taken into consideration when measuring an organization's ability to meet short-term obligations as they come due.

Line 14—Days of cash on hand. This measure is the average number of days of cash an organization currently maintains on hand with respect to its current direct medical and administrative costs. It reveals the number of days the organization is able to cover operating expenses with its current cash on hand. Specifically, this yardstick allows one to better evaluate the organization's cash management policy—which directly reflects the organization's ability to immediately meet its obligations as they come due without the need to liquidate any investments. All other things being equal, a rising ratio is considered positive (signifies increasing liquidity).

Line 15—Cash-to-claims-payable ratio. This ratio indicates the organization's ability to pay off (cover) its health, medical, and accounts payable with its available cash and cash equivalents.

Line 16—Days in premiums receivable. This measures the amount of premium revenue (measured in terms of days) due to the organization from the members. Additionally, it measures the organization's ability to convert its receivables to cash. If the organization's days in premiums receivable figure is getting higher (more and more days of premiums receivable), the organization may be having difficulty converting the receivables to cash and could encounter future liquidity problems.

Line 17—Days in unpaid claims. This ratio indicates the number of days of claims an organization owes its members. This ratio is useful for determining whether an organization is meeting its health and medical liabilities effectively and efficiently (in a timely manner). An upward trend in this figure could indicate that the organization is becoming less able to meet its obligations as they come due (that is, the organization's liquidity is decreasing).

Formulas for Indicators

Line 1—Net worth equals total assets minus liabilities.

Line 2—Total revenue is self-explanatory.

Line 3— Operating revenue equals total revenue less revenue from investments, interest, and other miscellaneous sources, plus co-payments.

Line 4—Operating profit or loss equals operating revenue less the sum of direct medical costs and administrative costs.

Line 5—Net profit or loss equals total revenue less direct medical costs less administrative costs less taxes and extraordinary expenses.

Line 6—Medical expense ratio equals medical and hospital expenses divided by operating revenue.

Line 7—Administrative expense ratio equals administrative costs divided by operating revenue.

Line 8—Overall expense ratio equals direct medical costs plus administrative costs divided by operating revenue.

Line 9—Operating profit margin equals operating revenue minus direct medical and administrative costs, divided by operating revenue.

Line 10—Overall profit margin equals total revenue minus direct medical costs, administrative costs, taxes, and extraordinary expenses, all divided by total revenue.

Line 11—Debt-to-service ratio equals the sum total of net income, provision for income taxes, interest expense, and depreciation, divided by the sum of interest expenses and current loans and notes payable.

Line 12—Current ratio equals current assets divided by current liabilities.

Line 13—The sum of current assets plus long-term bonds divided by current liabilities is self-explanatory.

Line 14—Days of cash on hand is computed under the following formula (cash + short-term investments) / ([total medical and hospital expenses plus total administrative expenses] / 365).

Line 15—Cash-to-claims-payable ratio equals the sum of cash and cash equivalents, divided by claims payable.

Line 16—Days in premiums receivable equals premiums receivable divided by (total premium revenue [commercial, Medicare, and Medicaid] plus fee-for-service revenue, divided by 365).

Line 17—Days in unpaid claims equals claims payable divided by (total medical and hospital expenses, divided by 365).

Worksheet C—Premiums & Cost Sharing (in Dollars per Member per Month)

Worksheet C reflects premiums and cost sharing that the M+C organization intends to charge per member per month for the M+C plan priced by this ACR. The amounts placed on this worksheet are limited by the amounts calculated on Worksheet E for Medicare enrollees.

ACR Values Needed for All Cost Sharing

Please include a separate ACR value for every cost-sharing amount in the PBP. HCFA reviewers will question any ACR that does not contain cost-sharing values per member per month that correspond to cost sharing in the PBP. Please ensure that all ACR entries reflect the correct health care component (line) and the correct statutory benefit category (column) in a manner consistent with the PBP.

No Grouping of Entries on Worksheet C

While HCFA may give case-by-case approval to organizations that request approval to group costs of certain health care components (lines) on Worksheet B, organizations cannot group cost sharing in either lines or columns of this worksheet.

Format of Cost-Sharing Entries

To ensure that cost-sharing amounts are properly recorded on Worksheet C of the ACR, please use as many decimal places as necessary for such entries. For example, do not round off a cost-sharing entry of $ 0.0005 to $ 0.00. Instead, enter $ 0.0005 in the appropriate cell. Even though the worksheet will round that amount to $ 0.00, the actual value will be recorded in the ACR database and will be used to verify that ACRs have cost-sharing entries that correspond to PBP cost sharing.

On Worksheet C, a positive entry obviously indicates the ACR value of cost sharing required by the plan. As described in the preceding paragraph, an entry of zero (i.e., $ 0.00) is a rounded value that signifies cost sharing of less than ½ cent per member per month. The worksheet, however, will not let users enter $ 0.00 to signify no cost sharing for an individual health care component or sub-component in a given statutory category. Therefore, leave cells *blank* if the PBP has no corresponding cost sharing.

Negative entries are not allowed on Worksheet C. Entering negative values will trigger error messages for affected cells. Furthermore, the worksheet will not allow text entries (e.g., “N/A”).

Part B-Only Plan Limits

Besides the normal ACR limitations on total charges for an M+C plan, there is an additional limit on premiums and cost sharing for Part A benefits offered to remaining Part B-only Medicare enrollees. An M+C organization can choose to include benefits equivalent to Medicare benefits

covered under Part A (inpatient hospital benefits, skilled nursing benefits, etc.) as an additional benefit, a mandatory supplemental benefit, or an optional supplemental benefit. The maximum that can be charged for the equivalent Part A benefits is the lesser of

- the ACR value of Part A benefits;
- the sum of the APR for Part A benefits, the actuarial value of Medicare's Part A deductible and coinsurance, and the ACR value of Medicare's Part A COBs; or
- the sum of the amount Medicare would charge for Part A benefits to individuals who otherwise do not qualify for Part A coverage and the actuarial value of Part A deductibles and coinsurance.

The limit on Part B-only plan premiums and cost sharing for Part A services is computed on Worksheet C1.

Private Fee-for-Service Plan Limits

The ACR form does not regulate premiums charged by an M+C PFFS plan. However, cost sharing charged to Medicare enrollees in such plans is limited to the ACR value of the benefit or group of benefits.

Line-by-Line Instructions

The following paragraphs provide detailed instructions for completing Worksheet C.

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Worksheet C can be expanded or contracted by clicking on the buttons in the upper right-hand section of the worksheet. To enter cost-sharing data, click on the "Expand Detail" button to display the sub-component lines. Doing so is necessary because most of the health care component lines contain formulas to sum the cost sharing for related sub-components and therefore are locked.

Once you have expanded the worksheet, enter the cost sharing in dollars and cents per member per month for every benefit subject to cost sharing in the PBP. Use the same line and column location in the ACR that was used for the benefit in the PBP. The PBP for any plan may have cost sharing identified in a note section as well as in individual data entry boxes. Please do not forget to include on Worksheet C the per-member per-month equivalents of cost sharing in PBP note sections.

The PBP permits assignment of deductibles to benefits at levels ranging from plan-wide to individual health care sub-components. ACR amounts for deductibles at the various benefit levels should be handled as follows:

- Plan-Level Deductibles—Enter ACR amounts for plan-level deductibles (i.e., deductibles that apply to all benefits of a plan) on line 13ded of the worksheet (Expanded). The organization should use its best estimates in allocating of the plan level deductible amounts to the correct statutory benefit categories.

- Other Deductibles—ACR amounts for deductibles that apply to certain health care components and sub-components can be aggregated on the appropriate health component line unless the organization wishes to allocate the amounts to sub-components. Enter ACR amounts for deductibles for specific health care sub-components on the same sub-component line used in the PBP. In both cases, organizations should assign the ACR costs to the same statutory benefit category used in the PBP. If the deductible cuts across more than one statutory benefit category, organizations should use their best judgment to allocate the deductible costs to the correct category. In the latter case, if Medicare-covered benefits are one of the categories, assume that Medicare-covered benefits are used first.

Column f computes the sum of columns d and e, to yield the subtotal of optional benefits charges for lines 1 through 21 respectively. The cells are locked.

Column h computes the sum of columns a, b, c, and f for lines 1 through 21 respectively, yielding the total charges to Medicare enrollees for each line. The cells are locked.

Enter on **lines 20 and 21,** as appropriate, any expected revenue from enrollees for cost sharing related to the coordination of benefits for benefits for which original Medicare would be the secondary payer.

Line 25 computes the sum of each column for lines 1 through 21. The cells for line 25 are locked.

Fill in **line 26** to reflect the premiums expected to be charged to Medicare enrollees for basic benefits (column b) and to Medicare enrollees for mandatory supplemental benefits (column d).

Worksheet C1—Part B-Only Maximum Charge for Part A Benefits (in $ per Member-Month)

Worksheet C1 is required for Part B-only plans. It is not relevant to Part A/B plans.

As stated in the discussion of Worksheet C, there is a limit on the maximum amount that can be charged (in terms of premiums and cost sharing) for certain benefits offered to remaining Part B-only Medicare enrollees. An M+C organization may choose to include benefits equivalent to Medicare benefits covered under Part A (inpatient hospital benefits, skilled nursing benefits, etc.) as an additional benefit, a mandatory supplemental benefit, or an optional supplemental benefit. The maximum that can be charged for the equivalent Part A benefits is the lesser of

- the ACR value of Part A benefits;
- the sum of the APR for Part A benefits, the actuarial value of Medicare's Part A deductible and coinsurance, and the ACR value of Medicare's Part A COBs; or
- the sum of the amount Medicare would charge for Part A benefits to individuals whom otherwise do not qualify for Part A coverage and the actuarial value of Part A deductible and coinsurance.

Worksheet C1 is provided to calculate the limit on Part B-only plan charges for Part A services. **The amount you enter on line 12 must be included on Worksheet C.** Cost-sharing amounts should appear on same line(s) and column(s) as in the PBP. Premiums should be included on line 26 for mandatory supplemental benefits and in column e for optional supplemental benefits. As stated above, the Part A benefits offered in a Part B-only plan can be classified only as additional benefits, mandatory supplemental benefits, or optional supplemental benefits. Please note that Part A benefits cannot be classified as Medicare-covered in a Part B-only plan.

The worksheet requires you to enter four values for Part B-only plans. Those values should be entered on lines 1, 3, 5, and 12. None of the values in the four cells can be negative. (Those four cells will be locked if the enrollee type is Part A/B.) The worksheet calculates or is pre-populated with the required values for lines 4, 6, 8, 9, 10, and 11. The enrollee type at the top of the form is imported from Worksheet A. The following paragraphs provide line-by-line instructions for completing Worksheet C1.

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Line 1. Enter on line 1 the ACR value of Part A benefits that your plan provides. If your Part B-only plan provides all Part A benefits *and* you have a plan of the same type in the same service area that covers Part A/B enrollees, the required ACR value is the difference between the ACRs for the two plans.

Line 3. Enter on line 3 the APR value of Part A benefits that your plan provides. If your Part B-only plan provides all Part A benefits *and* you have a plan of the same type in the same service area that covers Part A/B enrollees, the required APR value is the difference between the APRs for the two plans.

Line 5. Calculate the projected ACR value of Medicare Part A coordination of benefits for your projected working aged population. The value represents an estimate of the amount that you are entitled to collect from third-party payers (e.g., an enrollee's auto insurance company) when Medicare is the secondary payer for a given health care benefit.

Line 12. Enter your proposed charge to Part B-only enrollees for Part A benefits in this plan. Line 12 must be less than or equal to line 11. (Note that the cell on line 12, column b will turn red if that is not the case.) If you charge less than the maximum allowable, show the difference on Worksheet D.

REMINDER—Include any amount on line 12 of this worksheet in the appropriate cell(s) of Worksheet C.

Worksheet D—Expected Cost and Variation (in Dollars per Member per Month)

Worksheet D serves two purposes. First, it calculates and displays the total expected costs in dollars per member per month for each health care component. The worksheet breaks out the total expected cost of individual health care components into the four statutory benefit categories (i.e., Medicare-covered benefits, additional benefits, mandatory supplemental benefits, and optional supplemental benefits). Second, Worksheet D is the vehicle for reflecting any expected variations from trended values of costs for health care components per member per month.

The following sections provide general instructions for and information about the worksheet.

Trended Values

The worksheet computes **Trended Values** for individual health care components in four columns (a, c, e, and g), one for each of the statutory benefit categories. The computation of trended values for each statutory benefit category is the same, as follows. The trended value for the health care components of Medicare direct medical costs is the base period value of the component reported on Worksheet B adjusted by the direct medical care trend from Worksheet A. The trended value for administration costs is the base period value of administration reported on Worksheet B adjusted by the administration trend from Worksheet A. The trended value for the total is the base period value Medicare total costs reported on Worksheet B adjusted by the non-Medicare trend for collections from enrollees/initial rate from Worksheet A. The trended value for additional revenue is the result of subtracting the direct medical care subtotal (line 22) and administration (line 23) from the total trended value (line 25).

If organizations did not have non-Medicare enrollees in the base period and/or do not expect to have them in the contract year, initial rates cannot be computed. In that case, there will be no entries in columns a, c, e, and g. Similarly, no entries will appear in those columns if the plan did not incur any Medicare costs in the base period.

Adjusted Values

The **Adjusted Values** in columns b, d, f, and h reflect the sum of any expected variations (as described below) recorded on a given line and the trended value on same line in the column on the left. For example, the adjusted value for Medicare-covered home health benefits (line 6, column b) is the trended value on the same line under column a plus the expected variation on line 6, column b that you have entered on Worksheet D (Expanded).

If an organization chose to make no expected variation entries, the adjusted values would equal the trended values.

Expected Variations

Examples of Expected Variation Entries

The expected variation cells in Worksheet D (Expanded) allow you to incorporate information not accounted for in the trended values. For example, if Medicare adds another benefit to Medicare-covered benefits for the ACR, the cost of this benefit would not be reflected in base period costs. Therefore, an adjustment would be made to the computation to more closely approximate the cost that would be incurred for the Medicare population during the ACR period. Other examples would include

- changes in benefit design,
- the effect of changes in technology,
- non-relative changes in expected incurred costs, and
- expected changes in utilization patterns.

For M+C organizations offering M+C plans without non-Medicare enrollees in either or both the base period and the contract year, the trended value columns will be blank. The same is true for organizations without Medicare enrollees in the base period. As a result, such organizations must use the appropriate expected variations cell in Worksheet D (Expanded) to enter the expected contract year cost for individual health care components. Similarly, organizations offering new benefits should use the expected variation cells to record the expected cost of those benefits for the contract year. In both cases described above, organizations can use estimates for their initial submissions. **Such estimates should be documented clearly and should be developed using generally accepted accounting principles.**

The expected variation cells in Worksheet D (Expanded) also should be used to delete the trended value costs for any base year benefit not offered in the contract year. Moreover, as discussed later in this section, the expected variation entries can be used to dis-aggregate (i.e., apportion) trended values as necessary.

As stated before, Worksheet B should include only entries properly accrued to the base period, and those entries should track to certified financial statements for that period. Worksheet B should also include any corrections needed to the certified financial data if the changes were made within 75 days after the end of the base period. Corrections made after the 75-day period should be reported on Worksheet D (Expanded).

M+C organizations should use this worksheet to adjust for any errors in the formulas built into the electronic ACR. The adjustments should be annotated in a supplemental document as a "formula error," with the cell reference to identify which formula is in error.

No Grouping of Expected Variation Entries

Expected variation entries on Worksheet D, in terms of the classification by line and column, must be consistent with the PBP. Even though you secure approval from HCFA to group data for various health care components on Worksheet B, you cannot group any related expected variations for various health care components on Worksheet D. In other words, if you are grouping data for health care components on Worksheet B, and if column c, Part IB of Worksheet A displays a trend, the trended values on Worksheet D will be grouped. Although you are not usually required to dis-aggregate the trended values, you must enter expected variations in the correct line and column consistent with the benefit category used in the PBP for the plan benefits.

The following example illustrates that point. Consider an M+C organization that obtains HCFA approval to group costs of certain health care components on ACR Worksheet B. Assume that, in completing its ACR, the organization groups costs for preventive dental services (normally shown on line 16) together with the costs of preventive services on line 14 (Preventive Services) under the mandatory supplemental benefits column. In addition, assume that Part IB of Worksheet A computes a trend so that Worksheet D shows a trended value for the health care professional component under column e (Trended Value Mandatory Supp. Benefits). Because of the grouping on Worksheet B, the trended value on Worksheet D, line 14 includes costs of both benefits. Assume further that the organization needs to make an adjustment to the trended value that relates only to mandatory supplemental preventive dental benefits. While the organization would not have to dis-aggregate the trended values between the 2 health care components mentioned above, it would have to enter the expected variation under mandatory supplemental benefits on line 16 (Dental), not on line 14.

Format of Expected Variation Entries

To ensure that expected variations are properly recorded on Worksheet D, use as many decimal places as necessary. For example, do not round off an expected value entry of $ 0.0005 to $ 0.00. Instead, enter $ 0.0005 in the appropriate cell. The worksheet will round (and truncate) all entries of less than ½ cent per member per month to $ 0.00 (with the correct sign), but the actual value that you enter will be stored in the ACR database. Blank entries signify that no adjustments are necessary to the related trended value for a given statutory category. Therefore, leave cells *blank* if no adjustments are necessary to a particular trended value; the worksheet will not let users enter $0.00.

The worksheet will allow negative entries, however, it will not allow users to enter negative values large enough to make corresponding health care components (or related sub-components) negative on lines 1 through 19 and line 23 of the Medicare-covered, additional benefits, and mandatory supplemental categories.

The worksheet will not allow text entries (e.g., “N/A”).

Making Expected Variation Entries

To record any expected variations for individual health care components, click on the expanded version button at the top right of the electronic version of Worksheet D. Record expected variations on the expected variation line for each health care component under the appropriate statutory benefit category. As described above, the expected variations will be added to trended values on the same line in the next column on the right (the same statutory benefit category).

Other Information and Instructions

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Whenever cells on **lines 1 through 19 in columns a, c, e, and g** turn yellow, please enter the sub-component line numbers from Worksheet C (Expanded) for every sub-component covered by the particular expected variation entry. For example, if you enter an expected variation on line 14 (Preventive Services) of column a on this worksheet, and the variation covers both immunizations and diabetes monitoring, enter 14b and 14i, separated by a comma, in that cell.

Note that expected variation cells for line 20 (COB-Working Medicare), line 21 (COB-Other), line 23 (Administration), and line 24 (Additional Revenue) are blocked in column h (Adjusted Value Optional Supp. Benefits). Therefore, every expected variation entry related to optional supplemental benefits on lines 1 through 19 of column g must include an allowance for applicable administration costs, additional revenue, and COB collections.

Line 22—Subtotal Direct Medical Care is the subtotal of the preceding lines in each column.

Line 24—Additional Revenue, columns b, d, and f. Enter expected variations for additional revenue on line 24, columns b, d, and f. Generally those cells are used to make adjustments needed to correct errors on Worksheet E or to make the residual additional revenue values in columns a, c, and e of this worksheet more precise. To illustrate the latter use, consider that a loss incurred in a prior period can produce a loss in the ACR period based on the trended value computation. That situation may justify the need to increase additional revenue for the ACR period.

Please provide a separate written justification for any additional revenue expected variations with a positive sign.

Lines 1 through 25, column i show Adjusted Value Total Benefits, which is the contract year value of all health care components, including administration and additional revenue. The column sums the values on each corresponding line of columns b, d, f, and h. No entries are required; the cells are locked.

Line 25—Total sums lines 22, 23, and 24 in each column.

Justification of Expected Variations

All entries in expected variation cells in Worksheet D (Expanded) need to be justified in writing. Please submit such justifications with the paper copy of your ACR. Naturally, any justification provided should be in enough detail to fully explain the specific variation at issue. Some justifications can be very brief. For example, merely stating that an expected variation was needed to eliminate the costs in the worksheet for a previously offered benefit that is being dropped in the contract year would be adequate. Other justifications, such as one pertaining to the costs of a new benefit, need to be more detailed and must include *all* computations.

Worksheet E—Adjusted Community Rate (in Dollars per Member per Month)

Worksheet E calculates the ACR(s) for the M+C plan being offered. All cells are locked; no user entries are needed. The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Descriptions for other automatically calculated cells follow.

Part I—Standard Benefit Package (Unless otherwise noted, all lines relate to column a of Part I.)

Line 1 enters the APR from Worksheet A, Part I, column a, line 8.

Line 2 enters the direct medical care component of the initial rate from Worksheet D, column b, line 22.

Line 3 enters the administrative component of the initial rate from Worksheet D, column b, line 23.

Line 4 enters the additional revenue component of the initial rate from Worksheet D, column b, line 24.

Line 5 sums lines 2 through 4.

Line 6 enters the actuarial value of Medicare's deductible and coinsurance from Worksheet A, Part IA, column a, line 11.

Line 7 enters the actuarial value of Medicare's co-payment for psychiatric benefits from Worksheet A, Part IA, column a, line 12.

Line 8 subtracts the amount shown on lines 6 and line 7 from the ACR (line 5). The amount is called the adjusted ACR.

Line 9 subtracts the adjusted ACR amount (line 8) from the APR (line 1). The excess amount shown on this line must be used to fund contributions to a stabilization fund, additional benefits, and/or a reduction of premium. If the remainder equals a negative number (or zero), the worksheet will show $ 0.00 on line 9. That is because losses in excess of any APR cannot be charged to beneficiaries. If line 9 is $ 0.00, users can skip to line 22 if there are no error messages on lines between 11 and 21. If the error messages appear, users will have to make necessary corrections before proceeding to line 22.

Line 10 enters the amount to be deposited in or withdrawn from a stabilization fund from Worksheet A, Part IA, line 9. That number will be used to decrease or increase the amount HCFA will pay to the organization each month per Medicare enrollee.

Line 11 subtracts from the excess amount (line 9) any contributions to a stabilization fund (line 10). The remainder (the adjusted excess amount) must be used to fund additional benefits and/or a reduction of premium. If the remainder is less than zero, an error message will appear in the cell. In that case, you must adjust the amount on line 9, column a, Part IA of Worksheet A. The amount of any required adjustment is shown on line 11, column b. NOTE—For plans covering Part A/B enrollees, line 11 is the hospice rate described in 42 CFR 422.266 (c).

Line 12 enters the direct medical care component of the initial rate from Worksheet D, column d, line 22.

Line 13 enters the administrative component of the initial rate from Worksheet D, column d, line 23.

Line 14 enters the additional revenue component of the initial rate from Worksheet D, column d, line 24.

Line 15 sums lines 12 through 14. Additional benefits cannot exceed the amount on line 11. If they do, an error message will appear in the cell. Required adjustments can be made in Worksheet D—for example, in the appropriate column on the additional revenue line. The amount of any required adjustment is shown on line 15, column b.

Line 16 subtracts line 15 from line 11. The remainder ("Remaining Excess") must be used to fund a reduction in premiums. If the remainder is a negative number, additional benefits must be adjusted so that the remainder is either zero or a positive number.

Line 17 enters the actuarial value of Medicare's deductible and coinsurance from Worksheet A, Part IA, column a, line 11.

Line 18 enters the actuarial value of Medicare's co-payment for psychiatric benefits from Worksheet A, Part IA, column a, line 12.

Line 19 enters the amount from line 16—the remaining excess amount, to be used to fund a reduction in premiums—and gives it a negative sign.

Line 20 sums line 17 through line 19. That amount represents the maximum that a Medicare enrollee may be charged for Medicare-covered benefits and additional benefits (including all payments in the form of premiums, deductibles, coinsurance, and co-payments).

Line 21, column a, enters the total of all actual charges to the Medicare enrollee for Medicare-covered benefits and additional benefits. The worksheet sums the amounts found on Worksheet C, columns a and b, line 27. If this amount does not equal the amount on Worksheet E, column a, line 20, an error message will appear in the cell. In that case, please take one or more of the following actions:

- Check base period costs and trend values for errors. Make any required adjustments.

- Reduce charges (on Worksheet C) to the Medicare enrollee.

- Adjust additional revenue on Worksheet D (Expanded), using line 24 of column b or column d.

The amount of any required adjustment is shown on line 21, column b.

Line 22 enters the direct medical care component of the initial rate from Worksheet D, column f, line 22.

Line 23 enters the administrative component of the initial rate from Worksheet D, column f, line 23.

Line 24 enters the additional revenue component of the initial rate from Worksheet D, column f, line 24.

Line 25 sums lines 22 through 24.

Line 26, column a, enters the total of all actual charges to the Medicare enrollee for mandatory supplemental benefits. That amount is found on Worksheet C, column d, line 27. If this amount does not equal the amount in column e, line 25, please take one or more of the following actions:

- Check base period costs and trend values for errors. Make any required corrections.

- Reduce charges (on Worksheet C) to the Medicare enrollee.

- Adjust additional revenue on Worksheet D (Expanded), line 24, column f.

The amount of any required adjustment is shown on line 26, column b.

Line 27 enters the sum of line 21 and line 26. That sum represents the total amount that the Medicare enrollee may be charged for the benefit package.

Part II—Optional Supplemental Benefits

Regulations at 42 CFR 422.310(a)(3) require M+C organizations to calculate a separate ACR for each optional supplemental benefit offered under a specific M+C plan. Part II calculates those ACRs with data from other ACR worksheets. Even though individual health care components (as described on lines 1 through 19 on Part II) can be grouped under a single premium for marketing purposes, each health care component in a group must be priced individually on Part II. Thus, the maximum charge for a group of health care components would be the sum of the maximum charges for all of the components.

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Column a—Trended Value of Benefit Wks D. For lines 1 through 19 and 21 through 25, the worksheet enters the adjusted value of optional supplemental benefits shown on the corresponding line of column h, Worksheet D.

Column b—COB, Admin, and Revenue Allocation. For lines 1 through 19, the worksheet allocates COB (column a, line 21), Administration (column a, line 23), and Additional Revenue (column a, line 24) to each health care component, using the ratio of the cost of each health care component in column a to the cost of total direct medical care (column a, line 22).

Column c—ACR Before Adjustment. For lines 1 through 19, the worksheet enters the sum of corresponding lines of column a and column b. The resulting sum on each line is the ACR for the health care component, before the addition of any adjustments (expected variations) from Worksheet D.

Column d—Expected Variation Wks D. Column d copies the expected variations from each corresponding line of Worksheet D.

Column e—ACR/Maximum Charge. For coordinated care plans, lines 1 through 19, the worksheet enters the sum of corresponding lines of column c and column d. The resulting sum is the ACR for the health care component. It also is the maximum amount (premiums and cost sharing) that each Medicare enrollee can be charged for the optional supplemental benefit on that line. The amount shown on each line should be the same as the amount on the corresponding line of Worksheet C, column f. If an error message appears on any line of column e, the value hidden by "ERROR" does not equal the amount displayed on the appropriate lines of Worksheet C, column c. In that case, take one or more of the following actions:

- Check trend and base period values for errors and make any necessary corrections.
- Change the amounts on Worksheet C to agree with the amounts displayed on the corresponding lines of Worksheet E, Part II, column f.
- Adjust additional revenue on the appropriate line of column h, Worksheet D (Expanded).

The amount of any required adjustment for individual lines is shown on the corresponding line of column h. In some cases, that amount may have to be dis-aggregated and shown in more than one cell of the ACR form.

Column f—Cost Sharing Wks C. For lines 1 through 19, the worksheet enters the Medicare enrollee's cost sharing found on the corresponding lines of Worksheet C, column d.

Column g—Premiums. The worksheet enters the difference between column d and column e for lines 1 through 19 respectively. The amount displayed on each line is the maximum amount that each Medicare enrollee can be charged as a premium for the optional supplemental benefit on a monthly basis. The value displayed will equal the value shown on the corresponding line of Worksheet C, column e (Premiums).

Disclosure Statement

According to the Paperwork Reduction Act of 1995, no one has to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0742. The time required to complete this information collection is estimated to average 95 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s), or suggestions for improving this form, please write to HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 or to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.